

# Health Care Provider Fact Sheet

## Disease Name

### Alternate name(s)

### Acronym

### Disease Classification

### Variants

### Variant name

### Symptom onset

### Symptoms

### Natural history without treatment

### Natural history with treatment

### Treatment

### Other

### Physical phenotype

### Inheritance

### General population incidence

### Ethnic differences

### Population

### Ethnic incidence

### Enzyme location

### Enzyme Function

### Missing Enzyme

### Metabolite changes

### Gene

### Gene location

### DNA testing available

### DNA testing detail

### Prenatal testing

### MS/MS Profile

### OMIM Link

### Genetests Link

### Support Group

## Beta-ketothiolase deficiency

Alpha-methylacetoacetic aciduria, 2-methyl-3-hydroxybutyric acidemia, Mitochondrial acetoacetyl-CoA thiolase deficiency, MAT deficiency, T2 deficiency, 3-oxothiolase deficiency, 3-ketothiolase deficiency, 3-KTD deficiency BKD

Organic Acid Disorder

No, but there is considerable clinical heterogeneity

N/A

Late infancy or childhood. Mean age at presentation is 15 months (range 3 days to 48 months). There are documented cases of asymptomatic patients with enzyme deficiency. Frequency of decompensation attacks falls with age and is uncommon after the age of 10.

Symptoms include intermittent episodes of severe metabolic acidosis and ketosis accompanied by vomiting (often hematemesis), diarrhea and coma that may progress to death. There is great clinical heterogeneity between patients. Infancy is the period of highest risk for decompensation. Death or neurologic complications can occur. Neurologic damage includes striatal necrosis of the basal ganglia, dystonia and/or mental retardation. Other symptoms include cardiomyopathy, prolonged QT interval, neutropenia, thrombocytopenia, poor weight gain, renal failure and short stature. If neurologically intact, patients are normal between episodes.

Clinical outcome varies widely with a few patients suffering severe psychomotor retardation or death as a result of their initial attack and others with normal development and no episodes of acidosis.

Despite severe recurrent attacks, appropriate supportive care can result in normal development.

Avoidance of fasting. Bicarbonate therapy and intravenous glucose in acute crises. Possible protein restriction. Consider carnitine supplementation.

N/A

No dysmorphisms

Autosomal recessive

unknown

None known

N/A

N/A

Converts 2-methylacetoacetyl-CoA to propionyl-CoA and acetyl-CoA.

Catalyzes the decarboxylation of oxoacids.

Mitochondrial acetoacetyl-CoA thiolase enzyme

Increased urinary excretion of 2-methyl-3-hydroxybutyric acid, 2-methylacetoacetic acid, tiglylglycine, 2-butanone, and ketone bodies (acetoacetic acid, 3-hydroxybutyric acid).

ACAT1

11q22.3-q23.1

Not in US. Sequencing of gene on a research basis.

No common mutation known

Enzyme analysis in amniocytes or CVS tissue. If mutations have been identified, DNA testing is possible.

C5:1 tiglylcarnitine – elevated

[www.ncbi.nlm.nih.gov/entrez/dispomim.cgi?id=203750](http://www.ncbi.nlm.nih.gov/entrez/dispomim.cgi?id=203750)

[www.genetests.org](http://www.genetests.org)

Organic Acidemia Association

[www.oaanews.org](http://www.oaanews.org)

Save Babies through Screening Foundation

[www.savebabies.org](http://www.savebabies.org)

Genetic Alliance

[www.geneticalliance.org](http://www.geneticalliance.org)